ACCOUNTABLE CARE ORGANIZATION PAYMENT SYSTEMS

*payment***basics**

Revised:
October 2016

Accountable care organizations (ACOs) are groups of health care providers that have agreed to be held accountable for the cost and quality of care for a group of beneficiaries. The goals for ACOs are to improve coordination and quality of care, maintain beneficiary choice of provider, and reduce unnecessary services. Beneficiaries do not enroll in ACOs; instead, Medicare attributes beneficiaries to ACOs based on their Medicare claims history. The beneficiary is still free to use providers outside of the ACO. Providers both inside and outside the ACO generally continue to be paid their normal fee-for-service (FFS) rates by Medicare. If attributed beneficiaries choose to go to a provider outside of the ACO, the ACO remains responsible for this spending. This creates an incentive for the ACO providers to satisfy their patients and keep them in the ACO. Medicare provides ACOs with claims data for attributed beneficiaries to help the ACOs coordinate care. This design avoids some of the overhead costs associated with Medicare Advantage (MA) plans, such as marketing, enrollment, creating networks, and paying claims.

There are currently three different Medicare ACO programs. The Medicare Shared Savings Program (MSSP) is a permanent part of the Medicare program. It was created by the Patient Protection and Affordable Care Act of 2010 (PPACA) and became operational in 2012. The program has over 400 ACOs serving over 7.7 million beneficiaries. The second is the Pioneer ACO demonstration, which has 9 ACOs that served 330,000 beneficiaries in 2015. The Pioneer ACO demonstration, run by the Center for Medicare and Medicaid Innovation (CMMI), was designed to test innovative ways of compensating and regulating ACOs and was designed for ACOs that were already familiar with coordinating care and assuming risk. The demonstration ends in 2017.

A third ACO program, the Next Generation ACO demonstration, started in 2016 and now has 18 ACOs participating (counts of beneficiaries associated with Pioneer and Next Generation ACOs were not available at the date of publication). It incorporates higher levels of risk and reward than the other ACO programs and also includes provisions for beneficiary attestation and a small financial incentive for beneficiaries to use ACO providers. Spending targets are set differently so that they are more predictable and include a discount.

ACOs have formed in 49 states and Washington, DC. Most ACOs serve urban areas; only 14 percent serve predominantly rural and other low-population-density areas. Although the largest number of ACOs is in the South, the Northeast has the highest proportion of Medicare beneficiaries in ACOs.

What are ACOs accountable for?

Medicare ACOs are accountable for the total Medicare Part A and Part B spending for a defined population of beneficiaries and for the quality of their care.

Who can form an ACO?

ACOs are groups of providers such as physicians and hospitals. The group must include primary care providers because beneficiaries are attributed to ACOs based on their use of primary care services. Other providers such as specialists and hospitals can be included but are not strictly necessary. Unlike MA plans, ACOs do not need to have a network that provides all Medicare services. This is because Medicare beneficiaries who are attributed to ACOs can, like any other FFS beneficiary, go to any provider who accepts Medicare. Beneficiaries are not "locked in" to the ACO.

This document does not reflect proposed legislation or regulatory actions.

MEDPAC

425 I Street, NW
Suite 701
Washington, DC 20001
ph: 202-220-3700
fax: 202-220-3759
www.medpac.gov

Payment mechanics

When an ACO applies to the program, it specifies the providers in the ACO. Medicare then determines which beneficiaries received the plurality of their primary care from the providers in the ACO in the 'baseline' time period.[1] Those beneficiaries are then attributed to the ACO. Once the attributed beneficiaries are identified, CMS then computes the Part A and Part B spending (the "benchmark") for the beneficiaries during the baseline period. In the MSSP program, that baseline period is three years, and the spending is averaged over those three years with the most current expenditures given more weight.[2]

To determine the benchmark (or expected) expenditure amount for the ACO, the baseline expenditures are trended forward using trends in FFS spending. At the end of the year, actual expenditures for attributed beneficiaries are compared with the expected expenditures, and savings or losses are computed. If there are savings (that is, actual expenditures are less than expected), those savings are shared between the Medicare program and the ACO. If there are losses (that is, actual expenditures are greater than expected), those losses may be shared between the program and the ACO if the ACO has chosen to share risk with the program—a two-sided risk arrangement. (Losses are not shared under a one-sided risk arrangement.) Ninety-five percent of MSSP ACOs have chosen to be in a one-sided risk arrangement. Quality also enters into the calculation of shared savings and losses. Essentially, the higher the quality, the greater share of the savings the ACO receives (and the smaller the share of the losses in a two-sided risk arrangement). In the MSSP, this process is repeated each year of the three-year contract, and then the ACO baseline is rebased to start another contract period.

In the MSSP program, the actual shared savings rates and other parameters can vary depending upon which of the three payment tracks an ACO chooses. Track 1

Table 1 Parameters for the MSSP ACOs

Parameter	Track 1	Track 2	Track 3
Risk	One-sided	Two-sided	Two-sided
Minimum number of beneficiaries	5,000	5,000	5,000
Shared savings rate	50%	60%	75%
Performance payment limit	10%	15%	20%
Minimum savings rate (MSR)	Ranges from 2.0 to 3.9%*	Several options**	Several options**
ACOs in 2016	411	6	16
Shared loss rate	N/A	1 minus final shared savings rate***	1 minus final shared savings rate, but not less than 40%
Loss sharing limit	N/A	5% in year 1 7.5% in year 2 10% in year 3 and after	15%

Note: MSSP (Medicare Shared Savings Program), ACO (accountable care organization).
*MSR varies inversely with attributed population, from 2.0% for an ACO with 60,000 or more beneficiaries to 3.9% for ACOs with 5,000 beneficiaries.
**Option 1: no MSR; Option 2: MSR ranges from 0.5 to 2.0%; Option 3: as in Track 1
***The final shared savings rate = shared savings rate × quality score.

Source: Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2015. Medicare Shared Savings Program ACO final rule. *Federal Register* 80, no. 110. Medicare Shared Savings Program fast facts.

and Track 2 have been in effect since the program started in 2012. Track 3 started in 2016. Table 1 displays the options.

Almost all MSSP ACOs were in Track 1 in 2016. ACOs are now allowed to be in Track 1 for two three-year agreement periods. They will then have to transition to a two-sided risk arrangement, either Track 2 or Track 3.

ACOs in the Pioneer demonstration incur two-sided risk and have varied shared savings rates (from 60 to 70 percent) and varied minimum savings rates. ACOs in the Next Generation demonstration have two-sided risk and can have shared savings rates up to 100 percent.

Risk adjustment—Pioneer and MSSP take into account the changing health status of an ACO's population. The MSSP differentiates between continuously assigned beneficiaries and newly assigned beneficiaries. The hierarchical condition category (HCC) risk scores of the newly assigned beneficiaries are assessed, and if their average is different from the average HCC score of the ACO's original population, the benchmark is adjusted (e.g., if the newly attributed beneficiaries' average risk score were higher than the historical population's risk score, the trend for the benchmark would be adjusted up). The average risk score of the continuously assigned population is also assessed. It can decrease or it can increase; however, it is only allowed to increase as much as a population with similar demographics. The Pioneer demonstration uses a similar approach to risk adjustment.

Quality—CMS measures ACOs' quality in four domains:

- Patient/caregiver experience: 8 measures (16 possible points)
- Care coordination/patient safety: 10 measures (22 possible points; electronic health record measure is worth 4 points)
- Preventive health: 8 measures (16 possible points)
- At-risk populations: 5 measures (8 possible points; the diabetes measure is a composite of 2 measures)

The total number of points earned in a domain is divided by the maximum possible number of points, generating a domain score. Each domain score is weighted at 25 percent of the total quality score. The total quality score is multiplied by the shared savings rate to find the final shared savings rate. That rate is used to determine the amount of shared savings the ACO receives if the ACO achieves shared savings. In two-sided risk models, the final shared loss rate is one minus the final shared savings rate (with some limits), which means the higher the quality score, the lower the shared loss rate.

Quality benchmarks are computed using Medicare claims data, data from the Physician Quality Reporting System (PQRS), quality data reported by ACOs, and quality data collected from the larger Medicare FFS population. Starting in 2015, ACOs can score additional points for significant quality improvement (in contrast to attaining specified levels of performance), up to four points in each domain. However, the total points earned cannot exceed the maximum number of points possible in the domain.

Results to date

CMS reports that both the MSSP and Pioneer ACO programs have shown modest success. CMS reports that, overall, Pioneer ACOs achieved good quality metrics compared with traditional FFS providers for quality measures for which comparable results were available and that quality scores have improved over the life of the program. CMS also reported that MSSP ACOs had better results than FFS in many of the measures for which comparable results were available and that ACOs in the program in 2014 and 2015 showed improvement in their performance on quality measures over time.

Both programs have reported that some ACOs have achieved modest reductions in spending for health care services. The savings to date are often concentrated in ACOs in areas with high service use. Table 2 summarizes the 2015 financial results of the Pioneer demonstration and the MSSP.

Table 2 Summary financial results of Medicare ACOs, 2015

	Pioneer ACOs (12 ACOs)		Medicare Shared Savings Program (392 ACOs)	
	Millions of dollars	Percent	Millions of dollars	Percent
Benchmark	$5,490	100.0%	$73,298	100.0%
Actual spending	5,453	99.3	72,868	99.4
Savings	37	0.7	429	0.6
Paid to ACO	34	0.6	646	0.9
Returned to CMS	2	0.0	0	0.0
Net	+5	+0.1	–216	–0.3

Note: ACO (accountable care organization). Components may not sum to totals due to rounding.

Source: CMS data on 2015 ACO performance, August 2016.

After accounting for shared savings paid to ACOs and shared losses returned to CMS, Pioneer in 2015 showed small net savings to the Medicare program of under 1 percent. In April of 2015, the CMS Actuary certified that expansion of the Pioneer demonstration would reduce net program spending.[3]

However, taking into account bonus payments paid to ACOs, Medicare spent $216 more on the MSSP in 2015 than CMS estimates it would have otherwise spent in the absence of the program. This is because, although more MSSP ACOs (203, not shown in table) saved relative to their benchmarks than lost relative to their benchmarks (189), almost all MSSP ACOs are in one-sided models. Thus, even though in aggregate benchmarks exceeded actual expenditures by $429 million, Medicare paid out $646 million in shared savings to the ACOs that had shared savings and did not collect anything from the ACOs that had losses. ■

1 *Plurality of primary care* is defined as an ACO's practitioners providing the plurality of certain qualified evaluation and management services measured by charges for those services.

2 When resetting the benchmarks for subsequent three-year agreements, baseline years are weighted evenly, and regional expenditures will be factored in as well.

3 Office of the Actuary, Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2015. Memo: Certification of Pioneer model savings. April 10.